Exhibit A

Your Retiree Health Benefit Program

Summary Plan Description

NAVISTAR®

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General Information

Filing A Claim: Steps To Follow

Navistar has contracted with Aetna to process claims. Claims must be submitted to the Navistar/Aetna Benefits Payment Office no later than one year following the date of service. Failure to file the claim within the one-year timeframe will not invalidate claims where it is shown that it was not reasonably possible or not practicable to file within such time.

To receive reimbursement for covered services and supplies, follow these steps.

1. **If you are covered under Plan 1,** submit a completed claim form for a new illness to the Navistar/Aetna Benefits Payment Office. **In most cases, you need to complete only one claim form each calendar year for each covered individual.** Then, simply forward any additional bills to the Navistar/Aetna Benefits Payment Office. For some claims, such as convalescent care facility benefits, your physician may need to send Aetna periodic reports to verify the need for continued service.
2. **If you are covered under Plan 2,** Medicare will pay benefits first. Your Medicare Part A providers will submit your Part A expenses directly to Medicare; your Medicare Part B providers MAY submit your Part B expenses directly to Medicare. Ask your physician if he/she will submit claims to Medicare for you. When you receive your Explanation of Medicare Benefits form, forward it with a completed claim form to the Navistar/Aetna Benefits Payment Office. **You need only submit one completed claim form each year for each covered family member.**
3. **If you are covered under Plan 2 and enrolled in Medicare Direct,** your Medicare Part A providers will submit your Part A expenses directly to Medicare; your Medicare Part B providers MAY submit your Part B expenses directly to Medicare. Ask your physician if he/she will submit claims to Medicare for you. If not, you will have to submit them yourself. Medicare will automatically submit Part B claims to the Navistar/Aetna Benefits Payment Office for you. (See pages 159-160 for more information on Medicare Direct.)

Medical

General Information

Medical Benefits Request Form

A sample Medical Benefits Request Form is shown here. To speed your payment, be sure to complete **all** of the information that is requested. Pay careful attention to the following information.

1. **Section 1, Cardholder Information.**

   This is information about you, the Retiree or Surviving Spouse.

   - ✔ Fill in your Social Security Number. Your claim can't be processed without it.
   - ✔ If you are employed somewhere other than Navistar, tell us the name of your employer.
   - ✔ Check a box if you have other health care coverage.
   - ✔ Write in the Spouse's name and Social Security Number, too. This is important if there is more than one health care plan.

2. **Section 2, Patient Information.** This is the information we need about the person who actually received medical care.

   - ✔ Check a box to tell us whether the patient is you, a spouse, or another covered dependent.
   - ✔ Also, if the patient is a dependent and has a Social Security Number, be sure to fill it in.
   - ✔ If medical care was provided because of an accident, tell us what happened, when, where, and how the accident occurred.
   - ✔ If the patient is a dependent child, we need to know if the dependent is employed or has health care coverage other than through the Navistar Retiree Health Benefit Program.

3. **Sign and date the form.**

   Your signature authorizes Aetna to get the information it needs to process your claim for benefits. The date lets us know when your claim was submitted and when it was processed for payment.

Medical

General Information

Medical Benefits Request Form: Front (Sample)

NAVISTAR™

RETURN FOR PROCESSING TO:
Navistar/Ætna Benefits Payment Office
P.O. Box 5367
Rockford, IL 61125

MEDICAL BENEFITS REQUEST FORM

PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY

A COMPLETED SIGNED BENEFITS REQUEST FORM must be submitted once for yourself and once for your spouse each calendar year. SECTION I (EMPLOYEE/PATIENT INFORMATION) is to be completed by the employee. SECTION II (PHYSICIAN or PROVIDER INFORMATION) on the reverse side, must be completed by the provider of services. A completely itemized bill may be submitted in place of Section II. An itemized bill is one that shows the patient's name, relationship, date(s) of service, diagnosis and signature of physician or supplier. **(Please Use Black Ink)**

SECTION I: TO BE COMPLETED BY EMPLOYEE/RETIREE OR SURVIVING SPOUSE — TYPE OR PRINT ALL INFORMATION

1 CARDHOLDER INFORMATION

Name____ Soc. Sec. No. ____
Address____ City____ State____ Zip____
Check if New Address ☐ Telephone No. ( ) ____ Work Location____
Have You Terminated Employment with Navistar? Yes ☐ No ☐ If Yes, Date____
Are You Employed Elsewhere? Yes ☐ No ☐ If Yes, Name and Address of Other Employer____
Do You Have Other Group, HMO or Medicare Coverage? Yes ☐ No ☐ If Yes, Medical ☐ Dental ☐ Vision ☐ Hearing ☐ HMO ☐ Medicare ☐. Name of Other Insurer, Address and Policy No. (if known) ____
If Married, Spouse's Name____ Birthdate____ (Mo Da Yr) Is Your Spouse Employed? Yes ☐ No ☐
If Yes, Spouse's Soc. Sec. No. ____ Name and Address of Spouse's Employer____
Does Your Spouse Have Other Group, HMO or Medicare Coverage? Yes ☐ No ☐ If Yes, Medical ☐ Dental ☐ Vision ☐ Hearing ☐ HMO ☐ Medicare ☐.
Name of Other Insurer, Address and Policy No. (if known) ____

2 PATIENT INFORMATION

Sex: Male ☐ Female ☐
Name____ Soc. Sec. No. ____ Birthdate____ (Mo Da Yr)
Address: Same as Employee ☐ Other____
Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other____ Was Condition Related to Patient's Employment? Yes ☐ No ☐
Was Condition Related to an Accident? Yes ☐ No ☐ If Yes, Date ____ (Mo Da Yr) Time____ AM ☐ PM ☐ Description____
If Patient is a Dependent Child
Full Time Student (if over age 19)? Yes ☐ No ☐ If Yes, Where____
Is Dependent Child Shown as Exemption on Your Federal Income Tax Return? Yes ☐ No ☐
Is Dependent Child Employed? Yes ☐ No ☐ If Yes, Name and Address of Employer____
Does Dependent Child Have Other Group, HMO or Medicare Coverage? Yes ☐ No ☐ If Yes, Medical ☐ Dental ☐ Vision ☐ Hearing ☐ HMO ☐ Medicare ☐.
Name of Other Insurer, Address and Policy No. (if known) ____

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To all physicians and other health professionals, and hospitals and other health care institutions:
You are authorized to provide Ætna Life Insurance Company, Ætna Life Insurance Company of Illinois and any independent claim administrators and consulting health professionals and utilization review organizations with whom Ætna has contracted, information concerning health care, advice, treatment or supplies provided the Patient (including that relating to mental illness). This information will be used for the purpose of evaluating and administering claims for benefits.
Ætna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract.
This authorization is valid for the term of coverage of the policy or contract under which a claim has been submitted.
I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Date:____ Patient or Parent/Guardian Signature____

NOTE TO EMPLOYEES: Claim forms and envelopes may be obtained from your work location. Retirees and surviving spouses will be sent forms with each claim payment.

REV. 10/90

PRINTED IN USA

Medical

General Information

The physician must complete the back of the form.

4. First, he or she must indicate the name of the patient.
5. In this section, the physician provides a complete description of the dates of service, types of service, diagnosis, and charges. He or she must date and sign the form, and indicate if payment was made by you toward services.
6. This section explains how benefits will be paid: directly to a hospital, and/or directly to a physician UNLESS you include a receipt or the claim is clearly marked "Paid." Please keep a copy of any receipts submitted for your records.

   The Company, upon receipt of a notice of claim, will furnish to the claimant forms for filing proofs of claim. If such forms are not furnished **within fifteen (15) days** after the giving of such notice, the claimant shall be deemed to have complied with the requirements as to proof of his claim upon submitting written proof covering the occurrence, character, and extent of the occurrence for which claim is made.

Medical

General Information

Medical Benefits Request Form: Back (Sample)

NAVISTAR

RETURN FOR PROCESSING TO:
Navistar/Ætna Benefits Payment Office
P.O. Box 5367
Rockford, IL 61125

PATIENT NAME _____ 4

SECTION II
PHYSICIAN OR SUPPLIER INFORMATION (TO BE COMPLETED BY PHYSICIAN)

1. Date of:	Illness (First Symptom) or Injury (Accident) or Pregnancy (LMP)	2. Date first consulted you for this condition	3. Has Patient ever had same or similar symptoms? Yes ☐ No ☐
4. Name of Referring Physician			5. For services related to Hospitalization give Hospitalization dates Admitted / Discharged
6. Name and address of facility where services rendered *(if other than home or office)*			7. Was laboratory work performed outside your office? Yes ☐ No ☐ Charges

8. Diagnosis or nature of illness or injury *(Relate diagnosis to procedure in column D by reference to numbers 1, 2, 3, etc. or DX code)*
1.
2.
3.
4.

A DATE OF SERVICE	B Place of Service *	C Fully describe procedures, medical services or supplies furnished for each date given: ** CPT-4 Procedure Code	*(Explain unusual services or circumstances)*	D ICD-9 DIAGNOSIS CODE 11	E CHARGES		F (FOR AETNA'S USE ONLY)

5

9 ENTER THE TAXPAYER IDENTIFYING NUMBER TO BE USED FOR IRS REPORTING PURPOSES. YOU ARE REQUIRED UNDER AUTHORITY OF LAW TO FURNISH YOUR TAXPAYER IDENTIFYING NUMBER	10. Was payment made directly by patient employee? Yes____ No ____	11. Total Charge	12. Amount Paid	13. Balance Due
14. Your Patient's Account No.	15. Your Social Security No.	16. Physician or Supplier's name, address, zip code & telephone no.		

17 I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THAT THE FEES SUBMITTED ARE THE FEES I USUALLY CHARGE AND ACCEPT FOR SUCH PROCEDURES.

_____ Date_____
SIGNED (PROVIDER)

*PLACE OF SERVICE CODES

1–(IH) –Inpatient Hospital
2–(OH) –Outpatient Hospital
3–(O) –Doctor's Office
4–(H) –Patient's Home
5– Day Care Facility (PSY)
6– Night Care Facility (PSY)
7–(NH) –Nursing Home
8–(SNF) –Skilled Nursing Facility
9– Ambulance
0–(OL) –Other Locations
A–(IL) –Independent Laboratory
B– Other Medical Surgical Facility
C–(RTC) –Residential Treatment Center
D–(STF) –Specialized Treatment Facility

**PLEASE USE CPT-4 CODES

††PLEASE USE ICD-9-CM FOR DISCHARGE DIAGNOSIS

TO WHOM BENEFITS MAY BE PAID
Benefits for hospital expenses will be paid directly to the hospital. Benefits for physician/supplier expenses will be paid directly to them when you file a claim, unless a receipted bill is submitted as evidence that you have already paid the bill.
When sending bills to the Ætna, we suggest that you keep a record of the bills since the original bills must be retained by the Ætna for audit purposes.

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Medical

General Information

Explanation of Benefits (Plan 1)

When your claim is processed by Aetna, you will receive an Explanation of Benefits (EOB) detailing submitted and covered expenses. Be sure to keep your EOB for your information and records. **The claims office will not issue a duplicate.**

Explanation of Medicare Benefits (Plan 2)

If you are participating in Plan 2, you will receive an Explanation of Medicare Benefits (EOMB) since Medicare pays your benefits first. Unless you are enrolled in the Medicare Direct Program, you must submit this EOMB to Aetna to receive benefits payable under Plan 2.

Here is a sample of the information you will receive for Medicare Part A claims.

Nos. 1-2:
The top section shows your name, address and Medicare number.

Nos. 3-5:
This section shows the provider from whom you received services for the dates of the first and last service, and type of service provided.

No. 6:
This is the amount Medicare paid for covered services.

No. 7:
This is your Medicare carrier's address and telephone number.

Medical

General Information

Explanation of Medicare Benefits: Part A (Sample)

SST930128

U.S DEPARTMENT OF HEALTH AND HUMAN SERVICES/HEALTH CARE FINANCING ADMINISTRATION

MEDICARE BENEFIT NOTICE

DATE 02/11/93

1 John Doe
123 Main Street
Anytown, USA 12345

2 HEALTH INSURANCE CLAIM NUMBER
999-99-9999A

Always use this number when writing about your claim

THIS IS NOT A BILL

This notice shows what benefits were used by you and the covered services not paid by Medicare for the period shown in item 1. See other side of this form for additional information which may apply to your claim.

1 SERVICES FURNISHED BY	DATE(S)	BENEFITS USED
3 SWEDISH COVENANT 5145 N CALIFORNIA AV CHICAGO IL 60625	01/14/93 THRU 01/21/93	7 INPATIENT HOSPITAL DAYS 5

4

2 PAYMENT STATUS
6

MEDICARE PAID ALL COVERED SERVICES EXCEPT:
$676.00 FOR THE INPATIENT DEDUCTIBLE.

IF NO-FAULT INSURANCE, LIABILITY INSURANCE, WORKERS' COMPENSATION, DEPARTMENT OF VETERANS AFFAIRS, OR, IN SOME CASES, A GROUP HEALTH PLAN FOR EMPLOYEES ALSO COVERS THESE SERVICES, A REFUND MAY BE DUE THE MEDICARE PROGRAM. PLEASE CONTACT US IF YOU ARE COVERED BY ANY OF THESE SOURCES. YOU DO NOT HAVE TO CONTACT US TO REPORT A MEDICARE SUPPLEMENTAL (MEDIGAP) POLICY.

7 Your Medicare Carrier
Address
Telephone Number

If you have any questions about this record, call or write

TELEPHONE NUMBER

FORM HCFA-1533 (3-92)

Medical

General Information

Explanation of Medicare Benefits: Part B (Sample)

This is not a bill.

Explanation of Your Medicare Part B Benefits

JOHN DOE
500 WALL ST #622
SEATTLE, WA 98121-1509

1

Summary of this notice dated March 24, 1993

Total charges:	$ 56.53
Total Medicare approved:	$ 47.57
We are paying you:	$ 38.05

Your Medicare number is: 533-01-0692D

Details about this notice? See the back for more information.

Control number 0121-6233-60000

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You received these services from your provider:

SEATTLE RADIOLOGISTS, Mailing address: 1229 MADISON 9TH FL, SEATTLE, WA 98104-1357

Services and Service Codes	Dates	Charge	Medicare Approved	Notes
DR T LARSON				
1 x-ray exam series, abdomen [74022-26] professional charge	February 16, 1993	$ 18.40	$ 15.49	a
1 chest x-ray [71020-26] professional charge	February 18, 1993	12.94	10.88	a
1 x-ray exam of sinuses [70220-26] professional charge	February 18, 1993	14.59	12.27	a
1 chest x-ray [71010-26] professional charge	February 18, 1993	+ 10.60	+ 8.93	a
	Total	$ 56.53	$ 47.57	

Your provider did not accept assignment. We are paying you the amount that we owe you. See #4 on the back of this notice.

Notes:

a The approved amount for this service is based on the Medicare fee schedule in this locality.

Here's an explanation of this notice:

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Of the total charges, Medicare approved	$ 47.57	See #4 on the back.
Less Medicare copayment amount	- 9.52	We pay 80% of the approved amount; you pay 20%.
Approved amount less copay	$ 38.05	You have met the deductible for this year.
Medicare owes	$ 38.05	
We are paying you	$ 38.05	Please cash the enclosed check as soon as possible.

IMPORTANT: If you have questions about this notice, call KING COUNTY MED BLUE SHIELD at (206) 461-3711 or write to 13009 mi AVENUE, SEATTLE, WASHINGTON. You will need this notice if you contact us.
To appeal our decision, you must WRITE to us before December 27, 1993 at: PO BOX 21248, SEATTLE, WA 98111-3248.
See #2 on the back.

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General Information

The form on the preceding page is a sample of the information you will receive for Medicare Part B claims.

No. 1:
The top of the statement indicates your name, address, Medicare number, and a summary of the charges submitted and the amount Medicare paid.

No. 2:
The middle of the statement provides more detail about the charges. It includes the name of the physician, services provided, total amount of the charge, and the Medicare approved amount for each covered service.

No. 3:
The next section explains how your payment was determined. It calculates the total of Medicare approved charges, copayment amount, and amount being paid.

No. 4:
At the bottom of the statement, please note the name and telephone number of your Medicare carrier, and how to appeal the claim if you have information that would influence the payment decision.

The Medicare Direct Program

Medicare Direct is a computer system that forwards information about claims paid under Medicare Part B directly to Aetna. The program means less paperwork and faster claim payments for you. It is available in most states.

Who Is Eligible?
You are eligible to participate in the program if you are a:

- ✔ retiree age 65 or over who is enrolled in Medicare Part B,
- ✔ spouse age 65 or over who is enrolled in Medicare Part B, and
- ✔ the Navistar Retiree Health Benefit Program and Medicare are the only health care coverages you have.

The Medicare Direct program will process claims for just about every service that is covered under Medicare Part B. It will not process claims for Medicare Part A services or for Prescription Drugs.

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General Information

How Do I Enroll?

If you are eligible for Medicare and not already participating in the Medicare Direct program, call Navistar at **1-312-836-3187** and request an enrollment form and brochure. Complete the form and return it to Navistar. It's a convenient way to save time, money, and paperwork!

If you have not yet reached age 65, Navistar will automatically send you an enrollment form two months before your 65th birthday. Complete the form and return it to Navistar so you'll be enrolled in the Program when you are Medicare-eligible.

Aetna Customer Relations

If you have any questions about claims or benefits, contact the Aetna/Rockford Benefits Payment office. It is staffed with experienced customer relations specialists to help you with questions about:

- ✔ Dependent eligibility;
- ✔ Filing claims;
- ✔ How benefits are coordinated between plans;
- ✔ How to get additional claim forms; and
- ✔ Other types of benefit information.

Aetna/Rockford Benefits Payment Office
Hours are 8:00 a.m. to 5:00 p.m.,
(Central Standard Time)
Call **1-800-435-2969**

Be sure to have the following information ready when you call:

- ✔ Your Social Security Number;
- ✔ Your address and telephone number;
- ✔ Patient's name;
- ✔ Physician's diagnosis;
- ✔ The physician's name, specialty, address and telephone number.

Medical

General Information

Q: How long will it take to process my claim?

A: You should expect to receive payment within **10 working days** after the date your claim is received at the Aetna/Rockford Benefits Payment office.

Q: What can I do to speed up the processing of my claim.

A: The most important thing in processing a claim is to have complete information provided on the claim form and any supporting documentation. Otherwise, the claim may have to be pended, or held up while we wait for more information. This costs you time, and Navistar money. **Some important don'ts:**

- ✔ **Don't** submit a list of expenses you've prepared yourself. Send the actual bill(s) showing the name of the provider, the name of the patient, date and type of service, and the fee charged.
- ✔ **Don't** send canceled checks, cash register receipts, or bills with a "previous balance" or "balance forward" column. These can't be processed.
- ✔ **Don't** request copies of the bills you've submitted. Aetna must keep those with your file for audit purposes. Make copies of your claim and bills **before** you send them to Aetna.

Q: If I enroll in Medicare Direct, how will I know that Medicare sent my Part B claims on to Aetna to be processed?

A: When you receive your Explanation of Medicare Benefits statement, look for the following phrase: "Unpaid charges have been submitted for consideration to your complementary Medicare Insurer." This means that your claim was sent to Aetna. If you don't see this phrase, or if you don't receive payment within two weeks, contact your physician to be sure he/she submitted your claim.

Identification Cards

You'll receive an ID card when your coverage under Plan 1 or Plan 2 is effective. The ID card includes your name and Social Security number. **Keep it in a safe place. You'll need to show the card when you need health care services.** If your ID card is lost, misplaced, or stolen, contact Aetna at **1-203-636-0220**.

Medical

General Information

If Your Claim Is Denied

If a claim is wholly or partially denied under the Navistar Retiree Health Benefit Program, you will receive notice of the decision within **90 days** of receipt of the claim. The notice will be in writing, and will provide:

- ✔ The specific reason or reasons for the denial.
- ✔ Specific reference to pertinent provisions of the Program on which the denial is based.
- ✔ A description of any additional material or information necessary for you to resubmit the claim, and an explanation of why such material or information is necessary.
- ✔ An explanation of the claim review procedure.

You will have the opportunity to appeal a denial of a claim. For a full and fair review, send a written application to:

Manager, Employee Insurance
Navistar International Transportation Corp.
455 North Cityfront Plaza Drive
Chicago, IL 60611

You must make your appeal within one year of the date you receive the notice of denial of benefits. If you decide to appeal, you or your authorized representative:

- ✔ May review pertinent documents relating to the denial.
- ✔ May submit issues and comments in writing.

A decision will be made promptly, but not later than **60 days** after receiving your request for review. If special circumstances require an extension of time for processing, you will be notified in writing. In that case, a decision will be made as soon as possible, but not later than **120 days** after receiving your request for review.

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The decision on the review of your appeal will be provided in writing. It will include specific reasons for the decision, and specific references to pertinent provisions of the Program on which the decision was based.

If a claim is denied under Plan 2 because Medicare did not cover the expense, you cannot appeal the denial unless Medicare reverses their initial denial of payment. You must then furnish Aetna with written documentation from Medicare showing their payment.

Health Benefit Plan Committee

A seven (7) member joint Health Benefit Plan Committee has been established to resolve disputes following the regular claims procedure. Two members of the committee have been selected by the UAW; three by Navistar; one non-UAW retiree shall be appointed as described in the **Shy Settlement Agreement**; and one neutral member shall be elected by the other six. The Health Benefit Plan Committee may review and resolve benefit and eligibility disputes after the claim review procedure and will act in its sole discretion in resolving such disputes. The decision of the Health Benefit Plan Committee shall be final and binding on all parties.

In order to appeal a benefit denial or eligibility dispute to the Health Benefit Plan Committee, write to:

Health Benefit Plan Committee
c/o Navistar International Transportation Corp.
455 North Cityfront Plaza Drive
Chicago, IL 60611

Be sure to include all relevant documentation along with the reason for your request for review. In this appeal process, you are free to obtain assistance from your union representative, if applicable.

The Health Benefit Plan Committee may not approve payment for any benefit that is not covered under the Program. Any determination made by the Committee will be consistent with the Plan Document, but the Committee may consider relevant past practices, prior letters of agreement, or similar information in interpreting the Program.